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No. 99-210

IN THE

Supreme Court of the United States

OCTOBER TERM, 1999

Hospital Service District No. 1 of Tangipahoa Parish, *et al*,

Petitioners,

v.

Surgical Care Center of Hammond,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF *AMICUS CURIAE* NATIONAL ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS, IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*[1]

The National Association of Public Hospitals & Health Systems (NAPH) was founded in 1981 and currently represents over 100 public and non-profit safety net hospitals and health systems. Safety net hospitals and health care systems are outpatient and inpatient facilities that generally provide a disproportionate share of medical care in their communities to the low-income and hard-to-reach populations in a community, typically persons who are Medicaid-eligible or uninsured. Over 80 percent of services provided by NAPH members are to individuals covered by Medicare, Medicaid, or who are without any private insurance.[2] Almost all NAPH members have an obligation, either explicitly by state statute or otherwise as part of the stated mission of the institution, to provide medical care to all patients in need of care, regardless of insurance status or ability to pay. In 1996, just 66 NAPH members provided nearly one quarter of the uncompensated care in the United States.[3] A substantial majority of NAPH's member hospitals are either directly operated by a city or county, or are part of or are operated by the state, such as a

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[1] This brief was authored solely by counsel for the amicus curiae, National Association of Public Hospitals & Health Systems (NAPH). No person or entity other than NAPH has made a monetary contribution to the preparation or submission of this brief.

Petitioners and respondents have consented to the filing of this brief amicus curiae. Letters expressing consent to that effect have been filed with the Clerk of the Court.

[2] Testimony of Larry Gage, President of the National Association of Public Hospital & Health Systems, before the Senate Comm. on Finance, 106th Cong., 1st Sess. (May 27, 1999) (available on LEXIS Legis library, Cngtst file). A more typical hospital in the United States would have a caseload where nearly 40 percent of its patients are covered by private insurance.

[3] Larry Gage, *et al*, National Ass'n Pub. Hosp. & Health Systems, The Safety Net in Transition: America's Uninsured and Underinsured: Who Cares? 26 (1998).

state university hospital, a hospital district, authority, or a public benefit corporation.

Most safety net providers operate under enormous financial pressures. In recent years the business of health care delivery has witnessed convulsive changes, including very substantial reductions in payment as a result of the increased influence of managed care, increased demand for uncompensated care as the ranks of the uninsured grow, and drastically reduced federal and state support for safety net providers. In addition, a wave of integration, mergers, and consolidations has led to intensified pressures for more cost-efficient methods of delivering health care services.[4] As the number of uninsured Americans increases,[5] safety net providers face an increased demand for free care, especially providers located in urban city centers.[6] States' growing use of managed care for Medicaid recipients has forced safety net providers to compete for a population that represents a predominant source of their revenue, while public and private health insurers alike demand lower costs.[7]

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[4] *See, e.g.*, Robert A. Berenson, *Beyond Competition*, Health Aff., Mar./Apr. 1997, at 171, 173-74; Stephen A. Norton & Debra J. Lipson, The Urban Institute, Public Policy, Market Forces, and the Viability of Safety Net Providers 1 (1998).

[5] The number of uninsured individuals in the United States has increased by over 10 million over the last decade and is currently estimated at 43 million. Robert L. Bennefield, U.S. Dep't of Commerce Economic and Statistics Admin., Current Population Reports: Health Insurance Coverage: 1997 (Sept. 1998); Testimony of Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured, before the Subcomm. on Health and the Environment of the House Comm. on Commerce, 106th Cong., 1st Sess. (June 16, 1999) (available on LEXIS, Legis library, Cngtst file).

[6] Norton & Lipson, *supra* note 4 at 5-8. *See also* Paul B. Ginsburg, *The Dynamics of Market-Level Change*, 22 J. Health Pol., Pol'y & L. 363, 375 (1997).

[7] Ginsburg, *supra* note 6 at 366-67, 370-72.

Most NAPH members operate under the authority of the state or a state statute and are likely to enter into exclusive arrangements — the subject of the antitrust challenges below — in an effort to address current cost and efficiency pressures. NAPH and its members thus have a direct interest in the resolution of confusion surrounding the application of the antitrust state action immunity doctrine.

SUMMARY OF THE ARGUMENT

This Court's precedents have made clear that states are immune from federal antitrust liability. *Parker* v. *Brown*, 317 U.S. 341 (1943). This immunity also may extend to local governments, but only when two requirements are met: (1) local government actions must be authorized by state statute, and (2) the anticompetitive effects of the actions must be foreseeable. *See City of Columbia v. Omni Outdoor Advertising*, 499 U.S. 365 (1991); *Town of Hallie* v. *City of Eau Claire*, 471 U.S. 34 (1985).

The Fifth Circuit's *en banc* decision below departs from the well settled principles of *City of Columbia* and *Town of Hallie* by adding a requirement that state law must "necessarily contemplate" anticompetitive activity in order to provide local government state action immunity for a public hospital. *Surgical Care Center of Hammond, L.C.* v. *Hospital Service District No. 1 of Tangipahoa*, 171 F.3d 231, 235 (5th Cir. 1999).[8] In imposing this new requirement, the Fifth

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[8] *Surgical Care* reversed the decisions of both a Fifth Circuit panel, 153 F.3d 220 (5th Cir. 1998), and a federal district court, Civ. Action No. 97-1840 Section "D", 1997 U.S. Dist. LEXIS 12043 (E.D. La. Aug. 8, 1997). The Fifth Circuit summarily reversed two other cases on the strength of its *en banc* decision. *Willis-Knighton Medical Center v. City of Bossier City*, 178 F.3d 1290 (5th Cir. 1999)(Table), *rev'g* 2 F. Supp. 2d 842 (W.D. La. 1997); *Abraham v. Richland Parish Hospital Service District* 1-B, No. 98-30487 (5th Cir. 1999), *rev'g* Civ. Action No. 97-760 (W.D. La. May 1, 1998). *The Willis-Knighton* case recently settled, and *Abraham* has been consolidated with *Surgical Care* for the purposes of the petition at issue. All three cases are available in petitioners' submission. Pet. Br. App. 1-68.

Circuit essentially interprets *Town of Hallie*'s requirement that anticompetitive activity be "foreseeable" as instead a requirement that anticompetitive activity be actually "foreseen." To evaluate whether the Louisiana legislature "necessarily contemplated" anticompetitive conduct in this case, the Fifth Circuit went on intrusively to assess the "purpose" of the statute. 171 F.3d at 235.

In creating this requirement, the Fifth Circuit has both articulated an incorrect standard and misapplied this Court's state action immunity precedents in the context of public hospitals. Moreover, the Fifth Circuit's approach aggravates a split in the circuits and has already led to significant confusion for public hospitals. By generating confusion about the scope of actions that can qualify for state action immunity, the decision inhibits public hospitals from pursuing legitimate competitive strategies, increases the likelihood that their actions will face frequent legal challenges, places a financial burden on public hospitals, states and other governmental entities, and imposes precisely the type of burden on state legislatures that the antitrust state action immunity doctrine was intended to avoid. These consequences of the Fifth Circuit's decision are further exacerbated by its failure to address the extent to which Eleventh Amendment immunity may apply to governmental entities such as public hospitals.

NAPH therefore urges the Court to grant the petition for a writ of certiorari. We adopt and incorporate the broader arguments contained in the Petitioners' brief. This *amicus* submission focuses specifically on the Fifth Circuit's decisions as they relate in general to public hospitals and hospital systems operating under similar state statutes. In particular, this brief emphasizes the impact that the failure to grant the petition for a writ of certiorari will have on those hospitals and systems. This impact is quite substantial and weighs in favor of the Court granting the petition.

ARGUMENT

I. The Court Should Grant the Petition Because the Fifth Circuit's Decisions Below are Inconsistent with Prior Decisions of This Court

A. The Fifth Circuit's Interpretation and Application of "Foreseeability" Are Inconsistent with This Court's Prior Decisions

This Court has been very clear in stating that in examining whether anticompetitive actions are "foreseeable," the state statute need *not* "necessarily contemplate" anticompetitive actions.[9] By contrast, the Fifth Circuit in *Surgical Care* proclaimed that there is "a distinction between a statute that in empowering a municipality necessarily contemplates the anticompetitive activity from one that merely allows a municipality to do what other businesses can do." 171 F.3d at 235. The Fifth Circuit went on to assess whether the Louisiana legislature had foreseen potentially anticompetitive effects in enacting the legislation. *Id.* (assessing whether statutory language had "signals of insulation"). Since the actions addressed by the Fifth Circuit's opinions were clearly authorized under the Louisiana Hospital Service District law,[10] the only question under *Town of Hallie* and *City of Columbia* should have been whether the anticompetitive actions were "foreseeable," not whether they were actually "foreseen."

Viewed under the proper foreseeability criteria, the actions of the hospitals in these cases surely were entitled to immunity. All of the cases at issue in the petition dealt with exclusive

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[9] We incorporate Petitioners' arguments regarding the Fifth Circuit's erroneous application of Supreme Court precedents. Pet. Br. 14-21.

[10] *Surgical Care* addressed contracts authorized under La. Rev. Stat. § 46:1077. 153 F.3d at 233, 235. *Abraham* dealt with an emergency room services contract authorized under La. Rev. Stat. § 46:1077. Pet. Br. App. 62-64.

contractual arrangements.[11] Exclusive arrangements are an increasingly common feature of the health care marketplace. Commentators have noted that exclusive contracts provide important ways for hospitals to improve efficiency and quality of care.[12] These arrangements can allow the hospital efficiencies that may in fact reduce costs. *Jefferson Parish Hospital. Dist. No. 2* v. *Hyde*, 466 U.S. 2, 45 (1984) (O'Connor, J., concurring) (Exclusive arrangements "may be substantially procompetitive by ensuring stable markets and encouraging long-term, mutually advantageous business relationships."). Indeed, in a world of increasing managed care, exclusive contracts are a necessary tool for hospitals.[13] Numerous authorities have documented the spread of exclusive contractual arrangements. As one recently stated:

> In the 1980s, hospitals began entering into exclusive contractual arrangements with physicians and physician groups, typically for surgery or hospital-based specialties such as radiology, anesthesiology, and pathology. These arrangements are prompted both by an institutional desire to

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[11] In *Surgical Care*, a competing hospital sued in regard to exclusive managed care contracts for outpatient surgical care. 171 F.3d at 232. In *Abraham*, three physicians sued a public hospital when the hospital, which had an exclusive contract with a company to provide emergency care services, refused to allow them to provide those services. Pet. Br. App. 63-64.

[12] John J. Miles, Health Care & Antitrust Law, § 11:1 (1998).

[13] John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 Am. J.L. & Med. 173, 199 (1996)("In general, courts have looked favorably on restrictive contracting where procompetitive justifications are present. In fact, commentators have argued that for managed care to work, plans must have the ability to limit physician membership or face market failure." (citation omitted)). *See also* Bryan A. Liang, *An Overview and Analysis of Challenges to Medical Exclusive Contracts*, 18 J. Legal Med. 1, 34 (1997) ("As health care reform continues its presence within the political arena, significant changes in the provider landscape likely will make the exclusive contract a frequently used arrangement in contracting for physician and other health services.").

> enhance quality of care and by the need to introduce efficiencies into key departmental operations, and as such, these arrangements have strong underlying economic motivations. . . . Exclusive contracts are gaining popularity in managed care as plans seek to establish exclusive arrangements with particular physician networks.[14]

Because exclusive arrangements by their nature exclude some providers in favor of others, they have frequently been challenged on antitrust grounds. However, they have only rarely been found to actually violate the antitrust laws.[15] In fact, as one commentator has observed: "[A]lthough numerous such cases have been filed, plaintiffs have not won any reported decision ...."[16] Indeed, neither the Antitrust Division of the Department of Justice nor the Federal Trade Commission has "ever challenged an exclusive contract between a hospital and physicians . . . ."[17]

Given the fact that exclusive contracts are so ubiquitous in health care markets, it was erroneous for the court to find that it was not "foreseeable" that a public hospital would enter into such contracts, especially given that the legislation at issue broadly authorized Louisiana hospital districts to enter into contracts and joint ventures. And given the fact that lawsuits challenging such arrangements are both frequent in number and infrequently successful, it seems even more anomalous to infer that the legislature envisioned subjecting

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[14] Blum, *supra* note 13 at 181 (citations omitted).

[15] *See* David Marx, Jr., & James H. Sneed, American Health Lawyers Ass'n, Antitrust & Healthcare: Meeting the Challenge 230 (2d ed. 1998) ("Challenges to exclusive contracts both in the healthcare field and otherwise have generally not been successful."); Blum, *supra* note 13, at 182 ("By and large courts have upheld the validity of exclusive contracts ....").

[16] Miles, *supra* note 12, § 11:1, at 11-6 to 11-8 (regarding suits by physicians against hospitals).

[17] *Id.* at 11-9.

public hospitals to extensive lawsuits for these activities. Yet that is the anomalous result produced by the Fifth Circuit's decisions below.

The Fifth Circuit's determination that anticompetitive activities were not foreseen and that the purpose of the Louisiana Hospital Service District law was merely to "level the playing field" is also erroneous given the health care market context in which public hospitals operate. Public hospitals must be viewed as one part of a broader state scheme designed to address the state's health care needs. As noted above, public hospitals are typically obligated to provide medical care to all patients regardless of their insurance status or ability to pay — a mission that is becoming increasingly difficult to pursue. Public hospitals are subject to numerous governmental restrictions, including open meeting requirements, civil service requirements, and restrictions on procurement, budgetary flexibility, access to capital, and strategic planning. The public status of a hospital constitutes a substantial constraint on its ability to compete in today's highly competitive health care marketplace and succeed in its mission.

To infer that comparatively small changes in the contracting powers of public hospitals in Louisiana were intended to "level the playing field," as the Fifth Circuit did, ignores this larger context. If the state *truly* wanted to level the playing field, it would *privatize* the public hospitals, leaving them with no obligations and no restrictions greater than those faced by private hospitals. To the contrary, selectively reducing the disadvantages of public hospitals by enhancing their authority to contract and enter into joint ventures evinces a determination on the part of the state to continue the regulated and publicly supported status of the institutions, and thus to continue to treat public and private hospitals differently. It is quite unlikely that the same legislature could have contemplated that these marginal expansions of public hospital contracting authority would remove state action immunity from its public hospitals,

especially given the disruptive impact increased antitrust exposure would have on public hospitals struggling to meet unmet public health needs.

B. The Fifth Circuit Failed to Consider the Relevance of Sovereign Immunity Under the Eleventh Amendment

The Fifth Circuit's decision in *Surgical Care* contained only the briefest discussion of the Eleventh Amendment, noting that Eleventh Amendment immunity is "arguably a secondary source of protection for states from the federal antitrust laws." *Surgical Care*, 171 F.3d at 234.[18] However, the Eleventh Amendment is a *primary*, not a secondary, source of immunity for the states and their hospitals. When a state entity, or an entity that is viewed as a state agent, has an Eleventh Amendment defense to a federal antitrust claim, it presents a jurisdictional question, viz., can the state entity be subject to suit? In contrast, the question of whether an entity is immune from a federal antitrust challenge under the state action doctrine is a question of substantive law. Thus, courts should be obligated to determine whether Eleventh Amendment immunity applies as a jurisdictional issue before considering the merits of the case, including the applicability of the antitrust state action doctrine. *See, e.g., United States ex rel. Foulds* v. *Texas Tech University*, 171 F.3d 279, 288-89 (5th Cir. 1999), *petitions for cert. filed* 68 U.S.L.W. 3138 (U.S. Aug. 23, 1999)(No. 99-321), 68 U.S.L.W. 3153 (U.S. Aug. 27, 1999) (No. 99-365), (U.S. Aug. 27, 1999) (No. 99-513).

NAPH has a particular interest in the Court clarifying that an Eleventh Amendment jurisdictional analysis is a necessary prerequisite to any application of antitrust state

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[18] The court in *Surgical Care* did not offer any analysis or rule on the matter in part because the defendant was a local governmental entity. 171 F.3d at 234. The hospital district in *Surgical Care* does not appear to be asserting Eleventh Amendment immunity.

action immunity analysis, given that some courts have found Eleventh Amendment immunity to apply to state university hospitals. *Texas Tech University*, 171 F.3d at 289 n.14 (finding Texas Tech University Health Sciences Center "cloaked" with sovereign immunity as state institution); *Neo Gen Screening* v. *New England Newborn Screening Program*, No. 99-1100, 1999 U.S. App. LEXIS 17392 *8-9 (1st Cir. July 14, 1999) (finding University of Massachusetts' program for conducting genetic screening of newborns an arm of state because of University's mission, governance, financial relationship to state, and other factors); *Pharmaceutical & Diagnostic Services, Inc. v. University of Utah*, 801 F. Supp. 508, 510-13 (D. Utah 1990) (finding University of Utah's Colleges of Pharmacy and Medicine and its Intermountain Radiopharmacy arms of state for Eleventh Amendment purposes). As noted above, some of NAPH's members are state university institutions or have close state supervision.[19]

The Court's recent decisions on sovereign immunity have brought clarity and consistency to Eleventh Amendment jurisprudence. In *Seminole Tribe of Florida* v. *Florida*, 517 U.S. 44 (1996), this Court endorsed a two-part inquiry for determining when Congress has validly abrogated the States' sovereign immunity under the Eleventh Amendment. Under the first prong, Congress' intent to abrogate the states' Eleventh Amendment immunity must be "unmistakably clear" from the language of the statute in order for the legislation to have that effect. *Id.* at 56 (quoting *Dellmuth* v. *Muth*, 491 U.S. 223, 227-28 (1989)). A general authorization that a suit may be brought in federal court is not a sufficient expression of Congress' intent to abrogate Eleventh Amendment immunity. *Id.* Under the second prong, Congress must have acted pursuant to a valid exercise of power. *Id.* at 55. To

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[19] See the discussion of the Westchester County Health Care Corporation, *infra* II, for an example of a local public hospital authorizing statute where the state's governor appoints over half of the governing board.

date, the Court has recognized only one source of power as sufficient to abrogate Eleventh Amendment immunity: the enforcement clause (§ 5) of the Fourteenth Amendment, U.S. Const. amend. XIV, § 5. *Florida Prepaid Postsecondary Education Expense Board* v. *College Savings Bank*, 119 S. Ct. 2199, 2205-06 (1999) (*Florida Prepaid*); *College Savings Bank* v. *Florida Prepaid Postsecondary Education Expense Board*, 119 S. Ct. 2219, 2224-25 (1999); *Seminole Tribe*, 517 U.S. at 59.

Under these recent decisions, it is almost certain that the Sherman Act, which was enacted by Congress pursuant to the Commerce Clause, *United States* v. *E.C. Knight Co.*, 156 U.S. 1, 11-15 (1895), would not pass the second prong of the *Seminole Tribe* test. This is particularly true since the Court squarely rejected the Commerce Clause as a sufficient source of power for Congress to abrogate Eleventh Amendment immunity when it overruled *Union Gas*. *Pennsylvania* v. *Union Gas*, 491 U.S. 1, 17, 19-20 (1989)(holding that Interstate Commerce Clause gave Congress power to abrogate states' sovereign immunity), *overruled by Seminole Tribe*, 517 U.S. at 66. It is also likely that the Sherman Act would not pass the first prong. *See Parker* v. *Brown*, 317 U.S. at 350-51 (noting no suggestion of purpose in Sherman Act to restrain state action). Granting the petition for certiorari in this case would allow the Court to clarify that all inquiries under the antitrust state action doctrine must be preceded by a threshold determination that the Eleventh Amendment is inapplicable.

II. The Court Should Grant the Petition to Resolve the Profound Conflict Among the Circuits and Confusion Caused by the Fifth Circuit's Decision

The language of the Louisiana Hospital Service District law differs very little from the statutory language interpreted in cases decided by other circuits in which state action

immunity has been sustained.[20] The Fifth Circuit decision thus aggravates the existing conflict among the circuits. *See* Pet. Br. 21-28.

Because of the fundamental similarities between the Louisiana HSD law and other statutes governing public hospitals, the Fifth Circuit decisions create substantial confusion for public hospitals. In this section, we discuss three representative statutes that govern the activities of NAPH members as examples of statutes that provide authority similar to the Louisiana Hospital Service District law.[21] Two of the three statutes have been examined by the courts and were found sufficient to cloak the public hospital action in immunity.[22] This comparison illustrates that the confusion

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[20] Petitioners compare the Fifth Circuit decision to the decisions of the Ninth Circuit in *Lancaster Community Hospital* v. *Antelope Valley Hospital District*, 940 F.2d 397 (9th Cir. 1991)(addressing state action immunity in context of alleged antitrust violation by California hospital district in regard to contracts under its contracting authority), *cert. denied*, 502 U.S. 1094 (1992), the Eleventh Circuit in *F.T.C.* v. *Hospital Bd. of Dirs. of Lee County*, 38 F.3d 1184 (11th Cir. 1994)(addressing state action immunity in context of alleged antitrust violation by special act public hospital pursuant to its joint venture and acquisition authority) and the Fourth Circuit in *Coastal Neuro-Psychiatric Associates* v. *Onslow Memorial Hospital*, 795 F.2d 340, 342 (4th Cir. 1986)(addressing state action immunity in context of alleged antitrust violation by county hospital authority in regard to exclusive contract and authority to grant physician privileges). As the Petitioners note, there is no relevant distinction that can be made regarding whether the potentially anticompetitive actions at issue in the cases were more or less foreseeable under the statutes in each case.

[21] The Louisiana HSD law stated that the hospital service district "may contract with or engage in a joint venture with any person, corporation, partnership, or group of persons to offer, provide, promote, establish, or sell any hospital service." La. Rev. Stat. 46:1077. This language is similar to language in many other public hospital authorizing statutes.

[22] Both of these cases arose out of exclusive contracts by public hospitals under general contracting authority, similar to the Fifth Circuit cases. Many of the cases that have been filed against public hospitals regarding antitrust disputes arise in this context. *See, e.g.*, *Scara* v. *Bradley Memorial Hospital*, CIV-1-98-28, 1993 U.S. Dist. LEXIS 19908

caused by the conflict in the circuits has very real consequences for public hospitals throughout the United States, whether they are located inside or outside the Fifth Circuit, or in a circuit that has or has not explicitly addressed the issue. Public hospitals have (1) little ability to know whether they face potential lawsuits when arranging exclusive

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(E.D. Tenn. Feb. 4, 1993) (finding immunity in suit by physician denied anesthesiology privileges because public hospital had exclusive contract with Cleveland Anesthesiologists to provide such services); *Central Florida Clinic for Rehabilitation* v. *Citrus County Hospital Board*, 738 F. Supp. 459 (M.D. Fla. 1989) (finding immunity in lawsuit by a competing corporation claiming that an agreement between the public hospital and a third party was an attempt to monopolize patient therapy services), *aff'd without op.*, 888 F.2d 1396 (11th Cir. 1989), *cert. denied*, 495 U.S. 947 (1990).

Other lawsuits challenging similar arrangements have been analyzed under the public hospital's authority to make staffing decisions or grant privileges. *See, e.g.*, *Crosby* v. *Hospital Authority of Valdosta and Lowndes County*, 93 F.3d 1515 (11th Cir. 1996) (finding immunity in lawsuit by physician denied orthopedic surgical staff privileges), *cert. denied*, 520 U.S. 1116 (1997); *Coastal Neuro-Psychiatric Associates* v. *Onslow Memorial Hospital*, 795 F.2d 340 (4th Cir. 1986) (finding immunity in denial of privileges to radiologists based on exclusive contract with in-house physicians); *Wee* v. *Rome Hospital*, 93-CV-894 (FJS), 1996 U.S. Dist. LEXIS 5185 (N.D.N.Y. Apr. 15, 1996) (finding immunity in suit by physician relating to peer review process that resulted in loss of physician staff privileges); *Daniel* v. *American Board of Emergency Medicine*, 988 F. Supp. 127 (W.D.N.Y. 1997) (finding immunity (except where waived) for public teaching hospital defendants in a number of states in suit alleging antitrust violations in staffing practices regarding qualifications for certification examination for emergency physicians); *Shaw* v. *Phelps County Regional Medical Center*, 858 F. Supp. 954 (E.D. Mo. 1994) (finding immunity in termination of physician's privileges based on Board resolution to bring all anesthesiology services in-house); *Cohn* v. *Wilkes General Hospital*, 767 F. Supp. 111 (W.D.N.C. 1991) (finding immunity in denial of privileges); *Hatch* v. *North Colorado Medical Center*, Civ. Act. No. 85-F-2148, 1986 U.S. Dist. LEXIS 27631 (D. Co. Mar. 26, 1986) (finding immunity in suit by physician regarding denial of surgical privileges). Courts have almost always recognized antitrust immunity for public hospitals under the state action doctrine in either situation. Relitigation of these issues in both contexts may be the result of the Fifth Circuit's decision.

contracts with physician groups or others, and (2) may validly fear relitigation of issues already thought to be settled. The confusion may be magnified for public hospitals in circuits where the circuit court has not yet directly addressed public hospital immunity. Without review by the Supreme Court, an increasing number of lawsuits is probable, with increasingly inconsistent results.

Mississippi

Despite the fact that Memorial Hospital of Gulfport (MHG) has already engaged in protracted litigation to confirm that it has antitrust state action immunity under Mississippi's public hospital statute, there is a significant risk that a future antitrust action in Mississippi could rely on *Surgical Care* to reach an opposite result.

MHG, a member of NAPH owned jointly by the City of Gulfport and the Gulfport-West Harrison County Hospital District, was a defendant in an antitrust lawsuit filed in 1990 challenging the hospital's decision to deny a physician the right to perform chronic dialysis in the hospital's end stage renal disease (ESRD) units, based on an existing exclusive contract for the ESRD units with another physician. The United States District Court for the Southern District of Mississippi denied the hospital's motion for summary judgment claiming state action immunity. *Martin* v. *Memorial Hospital at Gulfport*, 881 F. Supp. 1087 (S.D. Miss. 1995). The Fifth Circuit reversed, finding that the public hospital was immune based on the state action immunity doctrine. *Martin* v. *Memorial Hospital at Gulfport*, 86 F.3d 1391 (5th Cir. 1996).

Applying *Town of Hallie* and *City of Columbia*, the Fifth Circuit found a sufficient indication that anticompetitive conduct was foreseeable in the contracting authority of the hospital. 86 F.3d at 1399. Under Miss. Code Ann. § 41-13-35, the board of trustees was authorized generally to "contract ... with ... any individual, partnership, corporation, ... or other health care facility, for the providing of property,

equipment or services by or to the community hospital or other entity or regarding ... operation of the community hospital ... and to terminate said contracts when deemed to be in the best interest of the community hospital." 86 F.3d at 1399 n.1 (quoting Miss. Code Ann. § 41-13-35(5)(g)).

Although the Fifth Circuit in *Surgical Care* attempted to distinguish *Martin* by emphasizing the existence of a certificate of need (CON) statute in Mississippi, there is nothing about the existence of a CON statute that indicates that potentially anticompetitive exclusive contracts were "foreseen" by the legislature, as opposed to being "foreseeable." There is nothing else in the community hospital statute that would indicate that the Mississippi legislature "necessarily contemplated" potentially anticompetitive actions.[23] *Surgical Care*, by reversing course from *Martin*, could spur new challenges in Mississippi. Thus MHG and other similarly situated public hospitals may once again face costly litigation.

Minnesota

The Fifth Circuit also creates confusion in other parts of the country where the courts had already found public hospital immunity in similar situations. In *Bloom* v. *Hennepin County*, 783 F. Supp. 418 (D. Minn. 1992), Hennepin County Medical Center (HCMC), an NAPH member owned and operated by Hennepin County, had an exclusive contract with a nonprofit corporation, Hennepin Faculty Associates (HFA), to provide all physician services at HCMC. A physician, upon being terminated from employment with HFA and subsequently denied privileges to see patients at HCMC, sued HCMC, HFA, Hennepin County,

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[23] In fact, the Fifth Circuit panel in *Surgical Care* was unable to distinguish the two statutes. *Surgical Care Center of Hammond, L.C.* v. *Hospital District No. 1 of Tangipahoa Parish*, 153 F.3d 220, 223 (5th Cir. 1998) ("This broad statutory language parallels the language we deemed sufficient to confer immunity in *Martin* ...."), *rev'd*, 171 F.3d 231 (5th Cir. 1999) (en banc).

the County Board of Commissioners, and others, claiming antitrust violations, breach of contract and other claims. 783 F. Supp. at 422. HCMC, which is operated under the authority of the Hennepin County Hospital Act, claimed antitrust immunity based on the state action doctrine. The main statute relied on by HCMC in its defense was a statute that allowed the Hennepin County Board of Commissioners to establish a department "for the purpose of providing comprehensive health care and related services as required by law and as determined . . . to be in the best interest of the county." 783 F. Supp. at 424 (quoting Minn. Stat. § 383B.211).

Correctly applying *Town of Hallie* and *City of Columbia*, the federal district court relied on the statute cited by the hospital, as well as other general authority allowing the county to provide services in the best interests of the county, to find that anticompetitive actions were foreseeable. 783 F. Supp. at 425 (citing Minn. Stat. § 383B.217[24]). The court stated that "[a]ny restraint on trade flowing from contracts entered into by HCMC is a necessary and reasonable consequence of the exercise of its statutory authority to contract for services, thus giving rise to an inference that state policy favors such displacement of competition." *Id.*

In *Bloom*, the court found HCMC's actions in regard to an exclusive contract for physician services to be immune under the state action doctrine by examining general authority regarding the provision of health care services. However, it is unclear whether the statute could pass the Fifth Circuit's

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[24] This statute states, in relevant part, that "Hennepin county may establish a medical center to provide hospital and medical services to the general public, including the indigent as defined by state and federal law, and as determined by the county board, and may provide for health education and training, and research, and may provide for other service as the board of commissioners determines, by resolution, to be in the best interests of the county...." Minn. Stat. § 383B.217(1). The statute also permits contracting and purchasing of "goods, materials, supplies, equipment and contracted services." Minn. Stat. § 383B.217(7)(a).

"necessarily contemplated" test. Since the Eighth Circuit has not addressed this issue, other public hospitals in the Eighth Circuit may be uncertain of what their statutes permit and which standard should apply. This uncertainty is likely to encourage lawsuits which will either result in further confusion regarding the continued relevance of *Bloom* or further aggravate the existing conflict between the circuits.

New York

The Fifth Circuit's decision will also cause uncertainty in circuits that have not yet addressed a particular piece of authorizing legislation. The Westchester County Health Care Corporation, a public benefit corporation in Westchester County, New York, and an NAPH member, is authorized by the Westchester County Health Care Corporation Act. N.Y. Public Auth. Law § 3300 *et seq.* Over half of the governing board of the Westchester County Health Care Corporation is appointed by the governor. N.Y. Public Auth. Law § 3303(1)(b).[25] The Act explicitly authorizes the corporation to "provide health and medical services for the public directly or by agreement or lease with any person, firm, or private or public corporation or association . . . ," N.Y. Public Auth. Law § 3306(2), and to "determine the conditions under which a physician may be extended the privilege of practicing within a health facility." N.Y. Public Auth. Law § 3306(6). There is no indication of whether the legislature contemplated anticompetitive conduct anywhere in the Westchester County Health Care Corporation Act.

Given that no court has ruled on whether the actions of the Westchester County Health Care Corporation are subject to state action immunity from the antitrust laws, the Westchester County Health Care Corporation, and other similarly situated public hospitals, cannot now predict their

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[25] Eight of fifteen directors are appointed by the governor, while the others are appointed by the county. Since the state controls over half of the public corporation, it is possible that the corporation may be immune as a state actor under applicable Eleventh Amendment case law. *See supra* I.B.

ability to engage in exclusive contracts free from antitrust challenge. Indeed, this confusion makes eventual challenge on antitrust grounds almost a certainty. This eventuality seems likely despite the fact that suits contesting exclusive contracts are rarely successful, and despite the fact that there is at least some likelihood that the Westchester County Health Care Corporation would be found to have Eleventh Amendment and/or state action immunity from the antitrust laws as either a state or local actor. Because of the possibility of extracting a settlement from a hospital already under financial pressure, a disgruntled provider excluded by even a procompetitive exclusive arrangement could view a lawsuit as an effective strategy, regardless of prospects on the merits.

III. The Court Should Grant the Petition to Address the Substantial Harm Caused by the Fifth Circuit's Errors

The Fifth Circuit's decisions are causing substantial confusion and harm. Confusion regarding the standard that applies to hospital actions necessarily will inhibit public hospitals from pursuing cost effective measures that enhance their competitive stance in the markets in which they operate. If public hospitals enter into exclusive contracts they may subject themselves to potentially costly litigation. If they do not, their ability to survive in the marketplace may be threatened, since they will be unable to operate the hospital as efficiently as possible in an increasingly competitive health care marketplace.

Uncertainty concerning the scope of state action immunity will prompt antitrust actions of dubious merit against public hospitals and could easily result in the expenditure of millions of dollars of public funds to defend them. Public hospitals are funded largely by public money, whether through a governmental budget line-item, direct subsidies provided by state or local governments, or indirectly through publicly-funded health care under Medicare or Medicaid. Increased litigation costs hamper the public hospital in carrying out its state-authorized public functions.

In addition, public hospitals, which often operate in difficult budgetary situations, are more likely than other institutions to be averse to subjecting themselves to potentially expensive litigation and may expend significant public funds to settle actions of ultimately dubious merit. Increased exposure to lawsuits will thus only detract from the public hospital's ability to deliver needed public services, services the states and localities involved are trying to deliver efficiently and effectively.

The confusion caused by the Fifth Circuit decision also places additional burdens on state legislatures as they struggle to determine what they must do to maintain immunity for the public hospitals operating under state statutes. In order to provide immunity to a public hospital, the state must either make the public hospital part of the state, thus permitting Eleventh Amendment immunity[26] or determine a way to convey to reviewing courts that all potentially anticompetitive uses of exclusive arrangements that could result from an authorizing statute have been "foreseen." In order to assure that they meet this demanding standard, state legislatures may need to re-examine their statutes and require significant changes. To the extent legislatures decide changes are needed to confirm the existence of intended state action immunity, legislatures may need to employ antitrust counsel to determine whether and how to make the appropriate findings to clarify their intent. The burden of foreseeing all potentially anticompetitive conduct will not be an easy one to meet,

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[26] While this Court has stated that the threat of antitrust liability should not influence the form which a corporate parent chooses for a subsidiary, *Copperweld Corp.* v. *Independence Tube Corp.*, 467 U.S. 752, 771-74 (1984), this is precisely the result dictated by *Surgical Care*'s "foreseen" standard. A state legislature determined to avoid the costs associated with interpreting *Surgical Care* and satisfying its requirements might reorganize its public hospitals simply to avoid its reach. Just as the parent in *Copperweld* had complete autonomy to select its subsidiary's corporate form, so too does a state legislature determine the form for its public hospitals, which are all creatures of state law.

particularly because investigations into the anticompetitive nature of exclusive contracts are necessarily fact specific and market-dependent. *See Jefferson Parish*, 466 U.S. at 44-47 (O'Connor, J.); *Omega Envtl., Inc.* v. *Gilbarco, Inc.*, 127 F.3d 1157, 1162-65 (9th Cir. 1997), *cert. denied*, 119 S. Ct. 46 (1998).

The impact of the Fifth Circuit approach in increasing the burdens on state legislatures to clarify their intent regarding state action immunity is particularly ironic given this Court's observation in *Parker* that the Sherman Act and its legislative history contained "no suggestion of a purpose to restrain state action." 317 U.S. at 351. The Fifth Circuit's decision would mandate additional legislation in order to assure application of state action immunity. The imposition of such an increased burden is contrary to the very principles of federalism that underlie *Parker* v. *Brown*.

CONCLUSION

For the above stated reasons, we urge the Court to grant the petition for a writ of certiorari.

Respectfully submitted,

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